Maryland Health Quality and Cost Council
Monday, March 12, 2012
Main Seminar Room, UMBC Technology Center
Baltimore, Maryland
9:30 a.m. – 12:00 p.m.

MEETING NOTES

Members present: Sec. Joshua Sharfstein (Vice Chair), Jill Berger, James Chesley, Richard "Chip" Davis, Barbara Epke, Peggy O'Kane (via telephone), Marcos Pesquera, E. Albert Reece, Jon Shematek, Kathy White, and Christine Wray.

Members absent: Lt. Governor Brown (Chair), Lisa Cooper, and Roger Merrill.

Staff: Laura Herrera, Katie Jones and Frances Phillips.

Meeting Materials

All meeting materials are available at Council's website:
http://dhmh.maryland.gov/mhqcc/meetings.html

Welcome and Approval of Minutes

The Secretary called the meeting to order at 9:40 AM. He welcomed the members and said the Lieutenant Governor was not able to participate in the meeting. The December 19, 2011 meeting minutes were approved.

Dr. Sharfstein thanked the Lieutenant Governor for his leadership and updated the Council on Health Care Reform and Implementation in Maryland. Bills to further define the Maryland Health Benefit Exchange are moving through the Maryland legislature.

UPDATE PRESENTATIONS

Health Disparities Workgroup – E. Albert Reece, University of Maryland School of Medicine

Dr. Sharfstein offered special thanks to the Lieut. Governor and Dean Reece for their development of and support of the "Maryland Health Improvement and Disparities Reduction Act of 2012" (House Bill 439 and Senate Bill 234) in committee hearings at the end of February. This effort has gained national attention with article on Health Enterprise Zones in the February 23rd issues of "Kaiser Health News." Dr. Reece reported that the Governor has added $4 Million to the Fiscal Year 2013 budget for activities outlined in the legislation.

Under the legislation, DHMH will work with the MD Community Health Resources Commission (CHRC) to develop eligibility criteria for HEZ designation, and to monitor progress towards an impact on health disparities by providers in the HEZ. Non-profit organizations and local government entities would be eligible to apply for the designation. The legislation asks the

Maryland Health Quality and Cost Council to convene a workgroup to study standards for cultural and linguistic competency; to determine feasibility of incorporation of standards for reporting and reimbursement purposes; and to submit a report to the Governor by January 1, 2013.

Ms. Barbara Epke was impressed with the recommendations' creativity, and she appreciated the workgroup's consideration of the need for eligibility criteria and performance indicators for the HEZs, though she is concerned with the limited number of HEZs. Dean Reece added the HEZ concept has gotten so much traction, that leadership in New York State and Georgia has inquired about the HEZs.

Health Care Delivery Reform Workgroup – Laura Herrera, DHMH

Dr. Herrera's demonstrated the workgroup's website as a tool for developing clinical services and payment innovations. The website link at: http://www.dhmh.maryland.gov/healthreform/SitePages/subcommittee.aspx is listed on the Council's website. The website features three types of projects: integrated, clinical innovations and financial mechanisms.

Dr. Herrera said the group is developing creative programs which enhance patient care, improve population health and cut cost**s.** To be listed on the site, a project must have completed or be in the process of completing a self-designed evaluation. A project uses one of three types of evaluation: experimental, quasi-experimental or non-experimental/ qualitative support. Marylanders having questions about any project's evaluation may contact that organization for more information.

In response to Dr. Jon Shematek's question, Dr. Hererra said the website is continuously updated with information about current and new projects. The Department tracks projects to assess outcomes, and projects are not retained in the program if they are not meeting goals.

High Deductible Health Plans – Julie Leis, Johns Hopkins Medicine

Dr. Leis presented background on high deductible health plans (HDHP), also called consumer directed health plans and characterized by lower premiums and higher deductibles than a traditional health plan. Dr. Leis explained the minimum annual deductible for HDHPs is $1,200 for individual coverage and $2,400 for family coverage. However, the average deductible is often much higher than the minimum. Dr. Leis focused on HDHPs paired with Health Savings Accounts as those are most commonly seen in the small group market.

Dr. Leis noted that proponents of HDHPs suggest they will increase the sensitivity of individual consumers to the costs of medical care, making them more cost-conscious and more likely to think carefully about seeking care. Detractors suggest that the ability of HDHPs to reduce system-wide spending is limited, and a small proportion of the population accounts for a large share of total health care spending, so decreasing spending will require substantially lowering the spending of the highest users of health care. Individuals with these plans may be more likely to avoid, skip, or delay health care because of costs, which may lead to more medical problems and increased costs long term. Dr. Leis said Maryland has seen an increase in the number of small businesses offering HDHPs since

2008. Data from carrier surveys indicate an increase in employers offering high deductible health plans, and fewer traditional plans.

Dr. Leis presented options for the state with a major recommendation: first, track growth of HDHPs, and their impact on health care access and costs; second, it will be critical to examine if healthier employees leave traditional plans for HDHPs and if this leads to an increase in premiums for those plans; third, data should be collected on coverage of preventive services; and fourth, require decreasing deductibles based on an individual's income.

Dr. Shematek complimented Dr. Leis on her comprehensive overview and suggested analysis of why preventive services are not promoted in the plans. Dr. James Chesley cited a difficulty with HDHPs in that people get charged when they seek follow up care and treatment as a result of preventive colon screening. Ms. Jill Berger said Marriott Corporation made preventive care free about four or five years ago, and mandated coverage for colonoscopy, but only for the colonoscopy. Dr. Shematek explained that colonoscopy is the most challenging to cover because it is considered surgery to remove polyps. The Secretary added that in a Medicare Health Maintenance Organization (HMO) plan, the colonoscopy is free, but not the follow up care.

Dr. Sharfstein said options for the Council to address the issue would be first, to ask MHCC to review Dr. Leis' recommendations as MHCC tracks these data, and second, to ask the major health insurers in the state how they communicate HDHP services to their members.

Evidence Based Medicine Workgroup – Richard 'Chip" Davis, Johns Hopkins Medicine

Dr. Davis updated the Council on the Hand Hygiene Initiative. Dr. Davis recommended that by the June 8, 2012 Council meeting there should be broader hospital participation in the initiative, with monthly data collection and reporting, and closer adherence to the project's goals, to standardized hand hygiene observation methods, and to data collection reporting requirements. Leadership for eight of the sixteen hospitals that have not been participating in the HH initiative have recommitted as of March 8, 2012 to their hospital's participation in the project. Dr. Davis said he anticipated broad voluntary participation from the hospitals. He noted that the Secretary has regulatory authority to require participation in the hand hygiene program.

Ms. Barbara Epke commented the initiative finally is seeing traction which perhaps can be attributed to pulling the CEOs together around the issue. Secretary Sharfstein agreed with Ms. Epke and Ms. Christine Wray that a hospital participating in another, rigorous program could be excused on a case-by-case basis from the statewide effort.

There was broad agreement at the meeting that broad, voluntary participation was preferable to regulatory action for hand hygiene.

Regulated Medical Waste – Clifford Mitchell, DHMH

Dr. Mitchell reported that the Regulated Medical Waste Workgroup recently met for the first time to identify opportunities and to make recommendations that will improve the management of medical waste. The goals, in line with DHMH's responsibility to regulate medical waste are to protect the public's health; protect the environment; improve the quality of health care; and

reduce health care costs. The Department's role is to determine if waste is infectious and its regulations describe the handling, treatment and disposal of infectious waste.

Outreach will be made to stakeholders including the Maryland Hospital Association and the Maryland National Capital Home Care Association. Possible work products for the group may include a market analysis of the medical waste treatment and disposal process, the technology of managing medical waste, health care quality and legal/regulatory issues, and potential demonstration projects.

State Health Improvement Plan – Madeleine Shea, DHMH

Dr. Shea reviewed SHIP's vision to increase life expectancy in Maryland across all racial and ethnic groups and geographic regions, with local action to improve health in Maryland communities. Seventeen regions across Maryland have formed local coalitions and are using 39 population health outcomes measures and determinants to identify baselines and 2014 targets. Dr. Shea discussed coalition funding, with CHRC planning up to seventeen awards from $25,000-$75,000 in 2012, and two to four bonus awards of $25,000-$50,000. Community Transformation Grants (CTG) also are available for advancing Local Health Improvement Coalition Priorities.

Dr. Shea briefly mentioned a *New England Journal of Medicine*, February 2, 2012 article which cited SHIP as effective collaboration between health systems and public health departments, with a common agenda for care and public health. Dr. Sharfstein said one of the criteria for HEZ approval would be how well the HEZ is integrated with the local health improvement plan.

Wellness and Prevention Workgroup and Healthiest Maryland Businesses – Christine Wray, MedStar St. Mary's Hospital

Ms. Wray focused on the workgroup's role in statewide wellness and prevention. Healthiest Maryland Businesses (HMB) currently includes 154 companies, reaching 208,000 Maryland employees. The first employer recognition event is March 29th in Salisbury, due to Dr. Merrill's continuing championship of the HMB initiative. The workgroup especially needs Council members' help in getting employers to participate in HMB evaluation and to share medical claims data. Ms. Wray offered a special thanks to Dr. Merrill for volunteering Perdue Farms Inc. to share data.

DHMH is collaborating with the Centers for Disease Control and Prevention on CTGs and will work with local health departments on the grant projects. The Council will provide guidance for CTG activities, and will disseminate resource materials and CTG success stories. DHMH is partnering with StateStat to identify action around improving the health of the State Workforce related to the food environment.

The workgroup identified possible future efforts and supports the CDC's Million Hearts Campaign to prevent 1 million heart attacks and strokes over the next 5 years. Maryland is the first state to announce a coordinated commitment to prevent heart disease and its risk factors with clinical management efforts and community initiatives, using the data-driven approach of

Governor O'Malley's StateStat program to improve efficiency and accountability in health promotion and disease prevention efforts.

Ms. Wray identified potential partners and said this is a great opportunity for the Council to lead the nation in coordinating a statewide plan to prevent heart disease and stroke. The Council could work to increase clinical prevention efforts statewide with focus on ABCS (Aspirin, Blood Pressure Control, Cholesterol Control, Smoking Cessation); to foster clinical innovations, and to enhance health information technology (HIT) with EHRs, registries and point of care improvement.

Dr. Kathleen White suggested employers as a good opportunity to promote prevention, and employer involvement to evaluate community health promotion activities.

Telemedicine– Secretary Joshua Sharfstein

Dr. Sharfstein briefly reviewed the February, 2012 letter sent to Senator Thomas Middleton and Delegate Peter Hammen, which cited the taskforce's recommendations and suggested designating MHCC as the lead agency for telemedicine. The letter noted that MHCC could begin work quickly on strategies to implement telemedicine in the state, discussed barriers to implementation and recommended MHCC support for a voluntary telemedicine demonstration project.

Ms. Wray said MedStar St. Mary's Hospital has used telemedicine, and the community is eager for telemedicine standards and regulations to address massive service shortages. She acknowledged that providers and clinicians' credentialing requirements would still have to be met, and she was concerned about standards for telemedicine in ambulatory care. Dr. Shematek commented that broadband availability depended on location. He also said a telemedicine program needed to ensure quality of the services, and adequate credentialing.

NEXT STEPS

Secretary Sharfstein reminded members that the next meeting of the Council is June 8, 2012 from 9:30 AM to12 noon at the UMBC Technology Center. The meeting then adjourned at 12:00 Noon.